# HOUSE BILL No. 1680

DIGEST OF INTRODUCED BILL

**Citations Affected:** IC 6-7-1; IC 7.1-4; IC 16-18-2; IC 16-46-5-7.5; IC 16-48.

**Synopsis:** Universal health care. Creates a plan of health insurance to provide primary coverage to every resident of Indiana. Creates the health insurance commission (commission) to administer the plan. Specifies minimum benefits that the commission must provide. Creates the health insurance trust fund from which covered health services and expenses of the commission would be paid. Raises taxes on tobacco products and alcoholic beverages. Imposes certain payments on individuals and employers. Provides that the commission is not required to provide for coverage of insured services before the later of January 1, 2008, or the date the commission has received appropriate federal approvals, assurances, or waivers that the Medicare, Medicaid, and veterans health programs can be integrated with the plan and that the plan can be implemented notwithstanding the Employee Retirement Income Security Act. Makes an appropriation to the commission.

**Effective:** July 1, 2007.



## Brown C

January 23, 2007, read first time and referred to Committee on Public Health.

Introduced

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.



# HOUSE BILL No. 1680

A BILL FOR AN ACT to amend the Indiana Code concerning health and to make an appropriation.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 6-7-1-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 12. (a) The following taxes are imposed, and shall be collected and paid as provided in this chapter, upon the sale, exchange, bartering, furnishing, giving away, or otherwise disposing of cigarettes within the state of Indiana:

(1) On cigarettes weighing not more than three (3) pounds per thousand (1,000), a tax at the rate of ~~two~~ **three** and seven hundred ~~seventy-five~~ **fifty-five** thousandths of a cent ~~($0.02775)~~ **($0.03755)** per individual cigarette.

(2) On cigarettes weighing more than three (3) pounds per thousand (1,000), a tax at the rate of ~~three~~ **five** and ~~six thousand eight hundred eighty-one ten-thousandths~~ **seventeen thousandths** of a cent ~~($0.036881)~~ **($0.05017)** per individual cigarette, except that if any cigarettes weighing more than three (3) pounds per thousand (1,000) shall be more than six and one-half (6 1/2) inches in length, they shall be taxable at the rate provided in subdivision (1), counting each two and three-fourths (2 3/4)

inches (or fraction thereof) as a separate cigarette.

(b) Upon all cigarette papers, wrappers, or tubes, made or prepared for the purpose of making cigarettes, which are sold, exchanged, bartered, given away, or otherwise disposed of within the state of Indiana (other than to a manufacturer of cigarettes for use by ~~him~~ **the manufacturer** in the manufacture of cigarettes), the following taxes are imposed, and shall be collected and paid as provided in this chapter:

(1) On fifty (50) papers or less, a tax of one-half cent ($0.005).

(2) On more than fifty (50) papers but not more than one hundred (100) papers, a tax of one cent ($0.01).

(3) On more than one hundred (100) papers, one-half cent ($0.005) for each fifty (50) papers or fractional part thereof.

(4) On tubes, one cent ($0.01) for each fifty (50) tubes or fractional part thereof.

SECTION 2. IC 6-7-1-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) Distributors who hold certificates and retailers shall be agents of the state in the collection of the taxes imposed by this chapter and the amount of the tax levied, assessed, and imposed by this chapter on cigarettes sold, exchanged, bartered, furnished, given away, or otherwise disposed of by distributors or to retailers. Distributors who hold certificates shall be agents of the department to affix the required stamps and shall be entitled to purchase the stamps from the department at a discount of ~~one and two-tenths~~ **ninety-three hundredths** percent ~~(1.2%)~~ **(0.93%)** of the amount of the tax stamps purchased, as compensation for their labor and expense.

(b) The department may permit distributors who hold certificates and who are admitted to do business in Indiana to pay for revenue stamps within thirty (30) days after the date of purchase. However, the privilege is extended upon the express condition that:

(1) except as provided in subsection (c), a bond or letter of credit satisfactory to the department, in an amount not less than the sales price of the stamps, is filed with the department; and

(2) proof of payment is made of all local property, state income, and excise taxes for which any such distributor may be liable. The bond or letter of credit, conditioned to secure payment for the stamps, shall be executed by the distributor as principal and by a corporation duly authorized to engage in business as a surety company or financial institution in Indiana.

(c) If a distributor has at least five (5) consecutive years of good credit standing with the state, the distributor shall not be required to

post a bond or letter of credit under subsection (b).

SECTION 3. IC 6-7-1-28.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 28.1. The taxes, registration fees, fines, or penalties collected under this chapter shall be deposited in the following manner:

(1) ~~Six~~ **Five** and ~~six-tenths~~ **twelve hundredths** percent ~~(6.6%)~~ **(5.12%)** of the money shall be deposited in a fund to be known as the cigarette tax fund.

(2) ~~Ninety-four~~ **Seventy-three** hundredths percent ~~(0.94%)~~ **(0.73%)** of the money shall be deposited in a fund to be known as the mental health centers fund.

(3) ~~Eighty-three~~ **Sixty-five** and ~~ninety-seven~~ **twelve** hundredths percent ~~(83.97%)~~ **(65.12%)** of the money shall be deposited in the state general fund.

(4) ~~Eight~~ **Six** and ~~forty-nine~~ **fifty-eight** hundredths percent ~~(8.49%)~~ **(6.58%)** of the money shall be deposited into the pension relief fund established in IC 5-10.3-11.

**(5) Twenty-two and forty-five hundredths percent (22.45%) of the money shall be deposited into the health insurance trust fund established by IC 16-48-6-1.**

The money in the cigarette tax fund, the mental health centers fund, or the pension relief fund at the end of a fiscal year does not revert to the state general fund. However, if in any fiscal year, the amount allocated to a fund under subdivision (1) or (2) is less than the amount received in fiscal year 1977, then that fund shall be credited with the difference between the amount allocated and the amount received in fiscal year 1977, and the allocation for the fiscal year to the fund under subdivision (3) shall be reduced by the amount of that difference.

SECTION 4. IC 7.1-4-2-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. An excise tax, referred to as the beer excise tax, at the rate of ~~eleven~~ **forty-one** and one-half cents ~~($.115)~~ **($0.415)** a gallon is imposed upon the sale of beer or flavored malt beverage within Indiana.

SECTION 5. IC 7.1-4-3-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. ~~Rate of Tax.~~ An excise tax at the rate of ~~two~~ **nine** dollars and sixty-eight cents ~~($2.68)~~ **($9.68)** a gallon is imposed upon the sale, gift, or the withdrawal for sale or gift, of liquor and wine that contains twenty-one percent (21%), or more, of absolute alcohol reckoned by volume.

SECTION 6. IC 7.1-4-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. An excise tax at the rate of **one dollar and** ~~forty-seven~~ **sixty-seven** cents ~~($0.47)~~ **($1.67)** a

gallon is imposed upon the manufacture and sale or gift, or withdrawal for sale or gift, of wine, except hard cider, within this state.

SECTION 7. IC 7.1-4-9-3, AS AMENDED BY P.L.224-2005, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) Except as **otherwise** provided in ~~subsection (b),~~ **this section,** the chairman shall deposit the monies collected under the authority of this chapter daily with the treasurer of the state, and not later than the fifth day of the following month shall cover them into the "excise fund" to be distributed as provided in this chapter.

(b) The chairman shall deposit the money received from the collection of the fees for a three-way permit under IC 7.1-3-20-16(f) daily with the treasurer of state, and not later than the fifth day of the following month shall transfer the money into the enforcement and administration fund of the commission under IC 7.1-4-11.

**(c) The chairman shall deposit:**

**(1) thirty cents ($0.30) of the beer excise tax rate collected on each gallon of beer or flavored malt beverage;**

**(2) seven dollars ($7) of the liquor excise tax rate collected on each gallon of liquor; and**

**(3) one dollar twenty cents ($1.20) of the wine excise tax rate collected on each gallon of wine;**

**daily with the treasurer of state and not later than the fifth day of the following month shall transfer the money into the health insurance trust fund established under IC 16-48-6-1.**

SECTION 8. IC 16-18-2-1.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 1.9. "Adjusted gross income", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-2.**

SECTION 9. IC 16-18-2-37.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 37.5. "Board" for purposes of:

**(1)** IC 16-22-8, has the meaning set forth in IC 16-22-8-2.1; **and**

**(2) IC 16-48, has the meaning set forth in IC 16-48-1-3.**

SECTION 10. IC 16-18-2-50.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 50.5. "Catastrophic illness", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-4.**

SECTION 11. IC 16-18-2-55.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 55.7. "Chronic illness", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-5.**

SECTION 12. IC 16-18-2-62 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 62. (a) "Commission", for purposes of IC 16-19-6, refers to the commission for special institutions.

(b) "Commission", for purposes of IC 16-31, refers to the Indiana emergency medical services commission.

(c) "Commission", for purposes of IC 16-46-11.1, has the meaning set forth in IC 16-46-11.1-1.

**(d) "Commission", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-6.**

SECTION 13. IC 16-18-2-62.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 62.5. "Committee", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-7.**

SECTION 14. IC 16-18-2-92.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 92.8. "Dependent", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-8.**

SECTION 15. IC 16-18-2-114 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 114. "Employer", for purposes of:

**(1)** IC 16-41-11, has the meaning set forth in IC 16-41-11-1; **and**

**(2) IC 16-48, has the meaning set forth in IC 16-48-1-9.**

SECTION 16. IC 16-18-2-116.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 116.5. "ERISA", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-10.**

SECTION 17. IC 16-18-2-121 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 121. "Executive director", for purposes of:

**(1)** IC 16-22, means the chief administrative officer, president, or other individual appointed under IC 16-22-3-8; **and**

**(2) IC 16-48, has the meaning set forth in IC 16-48-1-11.**

SECTION 18. IC 16-18-2-143 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 143. (a) "Fund", for purposes of IC 16-26-2, has the meaning set forth in IC 16-26-2-2.

(b) "Fund", for purposes of IC 16-31-8.5, has the meaning set forth in IC 16-31-8.5-2.

(c) "Fund", for purposes of IC 16-46-5, has the meaning set forth in IC 16-46-5-3.

(d) "Fund", for purposes of IC 16-46-12, has the meaning set forth in IC 16-46-12-1.

**(e) "Fund", for purposes of IC 16-48, has the meaning set forth**

**in IC 16-48-1-12.**

SECTION 19. IC 16-18-2-150.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 150.6. "Governmental body", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-13.**

SECTION 20. IC 16-18-2-179 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 179. (a) "Hospital", except as provided in subsections (b) through (f), means a hospital that is licensed under IC 16-21-2.

(b) "Hospital", for purposes of IC 16-21, means an institution, a place, a building, or an agency that holds out to the general public that it is operated for hospital purposes and that it provides care, accommodations, facilities, and equipment, in connection with the services of a physician, to individuals who may need medical or surgical services. The term does not include the following:

(1) Freestanding health facilities.

(2) Hospitals or institutions specifically intended to diagnose, care, and treat the following:

(A) Mentally ill individuals (as defined in IC 12-7-2-131).

(B) Individuals with developmental disabilities (as defined in IC 12-7-2-61).

(3) Offices of physicians where patients are not regularly kept as bed patients.

(4) Convalescent homes, boarding homes, or homes for the aged.

(c) "Hospital", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-5.

(d) "Hospital" or "tuberculosis hospital", for purposes of IC 16-24, means an institution or a facility for the treatment of individuals with tuberculosis.

(e) "Hospital", for purposes of IC 16-34, means a hospital (as defined in subsection (b)) that:

(1) is required to be licensed under IC 16-21-2; or

(2) is operated by an agency of the United States.

(f) "Hospital", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-6.

**(g) "Hospital", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-14.**

SECTION 21. IC 16-18-2-190.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 190.5. "Insurance contract", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-15.**

SECTION 22. IC 16-18-2-190.7 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 190.7. "Insured", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-16.**

SECTION 23. IC 16-18-2-190.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 190.8. "Insured services", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-17.**

SECTION 24. IC 16-18-2-224.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 224.5. "Medicare program", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-18.**

SECTION 25. IC 16-18-2-249.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 249.5. "Nominal gross domestic product", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-19.**

SECTION 26. IC 16-18-2-274 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 274. (a) "Person" means, except as provided in subsections (b), (c), and (d), an individual, a firm, a partnership, an association, a fiduciary, an executor or administrator, a governmental entity, or a corporation.

(b) "Person", for purposes of IC 16-25, has the meaning set forth in IC 16-25-1.1-8.

(c) "Person", for purposes of IC 16-31, means an individual, a partnership, a corporation, an association, a joint stock association, or a governmental entity other than an agency or instrumentality of the United States.

(d) "Person", for purposes of IC 16-42-10, has the meaning set forth in IC 16-42-10-3.

**(e) "Person", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-21.**

SECTION 27. IC 16-18-2-287.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 287.5. "Plan", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-22.**

SECTION 28. IC 16-18-2-287.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 287.8. "Poverty level", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-23.**

SECTION 29. IC 16-18-2-292.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 292.3. "Primary care provider",**

**for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-24.**

SECTION 30. IC 16-18-2-295 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 295. (a) "Provider", for purposes of IC 16-21-8, has the meaning set forth in IC 16-21-8-0.6.

(b) "Provider", for purposes of IC 16-38-5, IC 16-39 (except for IC 16-39-7) and IC 16-41-1 through IC 16-41-9 and IC 16-41-37, means any of the following:

(1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:

(A) A physician.
(B) A psychotherapist.
(C) A dentist.
(D) A registered nurse.
(E) A licensed practical nurse.
(F) An optometrist.
(G) A podiatrist.
(H) A chiropractor.
(I) A physical therapist.
(J) A psychologist.
(K) An audiologist.
(L) A speech-language pathologist.
(M) A dietitian.
(N) An occupational therapist.
(O) A respiratory therapist.
(P) A pharmacist.

(2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or described in IC 12-24-1 or IC 12-29.

(3) A health facility licensed under IC 16-28-2.

(4) A home health agency licensed under IC 16-27-1.

(5) An employer of a certified emergency medical technician, a certified emergency medical technician-basic advanced, a certified emergency medical technician-intermediate, or a certified paramedic.

(6) The state department or a local health department or an employee, agent, designee, or contractor of the state department or local health department.

(c) "Provider", for purposes of IC 16-39-7-1, has the meaning set forth in IC 16-39-7-1(a).

**(d) "Provider", for purposes of IC 16-48, has the meaning set**

**forth in IC 16-48-1-25.**

SECTION 31. IC 16-18-2-317.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 317.5. "Resident", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-26.**

SECTION 32. IC 16-18-2-317.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 317.6. "Resident individual", for purposes of IC 16-48, has the meaning set forth in IC 16-48-1-27.**

SECTION 33. IC 16-18-2-351.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 351.5. "Terminal illness", for purposes of:

**(1)** IC 16-25, has the meaning set forth in IC 16-25-1.1-9; **and**

**(2) IC 16-48, has the meaning set forth in IC 16-48-1-28.**

SECTION 34. IC 16-46-5-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 7.5. (a) This section applies beginning January 1, 2008.**

**(b) As used in this section, "provider" has the meaning set forth in IC 16-48-1-23.**

**(c) For each provider category, the state department of health shall annually designate the counties, cities, towns, and townships that are underserved by the provider category.**

**(d) For each provider category, the state department of health shall rank these areas according to the degree each area is underserved by the provider category.**

SECTION 35. IC 16-48 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

**ARTICLE 48. HEALTH INSURANCE COVERAGE ACT**

**Chapter 1. Applicability and Definitions**

**Sec. 1. This article applies beginning January 1, 2008.**

**Sec. 2. "Adjusted gross income" has the meaning set forth in IC 6-3-1-3.5.**

**Sec. 3. "Board" has the meaning set forth in IC 25-1-9-1.**

**Sec. 4. "Catastrophic illness" means any of the following:**

**(1) Burns on more than fifty percent (50%) of an individual's body.**

**(2) An individual's premature birth.**

**(3) An individual's birth with low birthweight.**

**(4) A malignancy requiring chemical or radiation therapy.**

**(5) An illness with treatment costs of more than fifty thousand**

**dollars ($50,000) in a year.**

**Sec. 5. "Chronic illness" means any of the following:**

**(1) An autoimmune disorder.**

**(2) A blood disorder.**

**(3) Cardiomyopathy.**

**(4) Chronic obstructive pulmonary disease.**

**(5) Cirrhosis of the liver.**

**(6) Cystic fibrosis.**

**(7) Diabetes.**

**(8) End stage renal disease with dialysis.**

**(9) Severe neuromuscular disease.**

**(10) Status/post transplant.**

**(11) Polycystic kidney disease.**

**(12) Serious and persistent mental illness.**

**(13) An illness with treatment costs of more than fifty thousand dollars ($50,000) in a year.**

**Sec. 6. "Commission" refers to the health insurance commission established by IC 16-48-3-1.**

**Sec. 7. "Committee" refers to the health care claims review committee appointed under IC 16-48-8-1.**

**Sec. 8. "Dependent" means either of the following:**

**(1) A child, a stepchild, or an adoptee (as defined in IC 31-9-2-2) of an insured who is:**

**(A) unemancipated; and**

**(B) less than nineteen (19) years of age.**

**(2) An individual more than one-half (1/2) of whose support is provided during a year by an insured.**

**Sec. 9. "Employer" means an individual or a corporation (as defined in IC 6-3-1-10) that employs in Indiana at least one (1) resident individual.**

**Sec. 10. "ERISA" refers to the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.).**

**Sec. 11. "Executive director" refers to the executive director employed under IC 16-48-3-12.**

**Sec. 12. "Fund" refers to the health insurance trust fund established by IC 16-48-6-1.**

**Sec. 13. "Governmental body" means any of the following:**

**(1) A state agency (as defined in IC 4-13-1-1).**

**(2) The legislative branch of state government.**

**(3) The judicial branch of state government.**

**(4) An instrumentality of the state that performs essential governmental functions.**

**(5) The state lottery commission created by IC 4-30-3-1.**

**(6) A political subdivision (as defined in IC 36-1-2-13).**

**(7) A state educational institution (as defined in IC 20-12-0.5-1).**

**(8) The federal government or an agency or instrumentality of the federal government.**

**(9) The government of a state or territory of the United States.**

**(10) A political subdivision of a state or territory of the United States.**

**Sec. 14. "Hospital" refers to a hospital or an ambulatory outpatient surgical center licensed under IC 16-21-2.**

**Sec. 15. "Insurance contract" means a contract for insurance for the payment of, reimbursement of, or indemnification for any part of the cost of an insured service provided in Indiana.**

**Sec. 16. "Insured" means an individual insured by the plan.**

**Sec. 17. "Insured services" means health care services covered by the plan.**

**Sec. 18. "Medicare program" refers to Parts A, B, and D of the Medicare program (42 U.S.C. 1395 et seq.).**

**Sec. 19. "Nominal gross domestic product" refers to the nominal gross domestic product as determined by the United States Department of Commerce and published by the Bureau of Economic Analysis or the United States Department of Commerce.**

**Sec. 20. "Overserved area" refers to an area overserved by primary care providers designated by the state department of health under IC 16-46-5.**

**Sec. 21. "Person" means any of the following:**

**(1) An association.**

**(2) A corporation.**

**(3) An estate.**

**(4) A governmental body.**

**(5) An individual.**

**(6) A partnership.**

**(7) A professional corporation.**

**(8) A trust.**

**(9) A limited liability company.**

**(10) A joint venture.**

**(11) A proprietorship.**

**Sec. 22. "Plan" refers to the health insurance plan established under IC 16-48-5-1.**

**Sec. 23. "Poverty level" refers to the federal income poverty level as determined annually by the federal Department of Health**

**and Human Services.**

**Sec. 24. "Primary care provider" means a health care provider that provides health care services as the provider of first contact and means of entry into the health care system.**

**Sec. 25. "Provider" means any of the following:**

**(1) A community mental health center.**

**(2) A community or migrant health center (as defined in IC 16-46-5-1).**

**(3) A community retardation and other developmental disabilities center.**

**(4) A home health agency.**

**(5) A hospital.**

**(6) A person authorized by law to provide health care or professional services in Indiana as any of the following:**

**(A) A chiropractor.**

**(B) A dentist.**

**(C) A licensed practical nurse.**

**(D) A registered nurse.**

**(E) An optometrist.**

**(F) A pharmacist.**

**(G) A physical therapist.**

**(H) A physician.**

**(I) A podiatrist.**

**(J) A psychiatrist.**

**(K) A psychologist with a doctorate in psychology.**

**(L) A social worker.**

**(M) A clinical social worker.**

**(N) An osteopath.**

**Sec. 26. (a) "Resident" means an individual who:**

**(1) lives in Indiana; and**

**(2) either:**

**(A) has lived in Indiana continuously for at least one (1) year; or**

**(B) is a dependent of an individual who has lived in Indiana continuously for at least one (1) year.**

**(b) The term does not include an individual who lives in Indiana only to attend a school, college, or university located in Indiana.**

**Sec. 27. "Resident individual" means an individual who is a resident of Indiana for Indiana adjusted gross income tax purposes.**

**Sec. 28. "Terminal illness" means any of the following:**

**(1) Acquired immune deficiency syndrome (AIDS).**

**(2) A malignancy that results in a diagnosis of a life expectancy of less than six (6) months for the individual suffering from the malignancy.**

**(3) An illness:**

**(A) with treatment costs of more than fifty thousand dollars ($50,000) in a year; and**

**(B) that results in a diagnosis of a life expectancy of less than six (6) months for the individual suffering from the illness.**

**Sec. 29. "Underserved area" refers to a shortage area underserved by providers designated by the state department of health under IC 16-46-5-6.**

**Chapter 2. General Provisions**

**Sec. 1. This article entitles an insured the freedom to choose the insured's own provider.**

**Sec. 2. Except as provided in section 3 of this chapter, this article does not impose an obligation on a provider to treat an insured.**

**Sec. 3. A provider may not deny insured services to an insured on the basis of any of the following:**

**(1) Color.**

**(2) Income level.**

**(3) National origin.**

**(4) Nonmedical criteria.**

**(5) Race.**

**(6) Religion.**

**(7) Sex.**

**(8) Sexual orientation.**

**Sec. 4. The commission and the plan are not subject to regulation by the department of insurance or the insurance commissioner under IC 27-1.**

**Sec. 5. The commission is subject to IC 5-14-1.5.**

**Sec. 6. (a) The commission is subject to IC 5-14-3.**

**(b) Information relating to an insured or a provider may not be disclosed except as provided in IC 5-14-3.**

**(c) The commission may publish information received under this article in statistical form if the identities of individuals and providers are not revealed, except as permitted by IC 5-14-3.**

**Sec. 7. A nonparticipating provider may not be reimbursed by the plan for covered services in an amount greater than the amount paid to a participating provider.**

**Chapter 3. Health Insurance Commission**

**Sec. 1. The health insurance commission is established.**

**Sec. 2. The commission consists of the following members:**

**(1) The following voting members appointed by the governor:**

**(A) Four (4) members representing business other than health care or insurance. At least one (1) member appointed under this clause must represent small business. Not more than one (1) member appointed under this clause may represent a particular industry.**

**(B) Four (4) members representing organized labor.**

**(C) Seven (7) members who have no interest in health care other than as consumers. At least two (2) members appointed under this clause must be at least sixty-five (65) years of age.**

**(D) Two (2) members representing providers. The members appointed under this clause may not be members of the same licensed profession.**

**(E) Two (2) members who are actuaries.**

**(2) Four (4) nonvoting advisory members appointed as follows:**

**(A) The speaker of the house of representatives shall appoint two (2) members of the commission from among the members of the house of representatives. The members appointed under this clause may not be members of the same political party.**

**(B) The president pro tempore of the senate shall appoint two (2) members of the commission from among the members of the senate. The members appointed under this clause may not be members of the same political party.**

**(3) The following individuals serve as nonvoting advisory members of the commission:**

**(A) The commissioner of the state department of health or the commissioner's designee.**

**(B) The secretary of the office of family and social services or the secretary's designee.**

**(C) The commissioner of insurance or the commissioner's designee.**

**(D) The commissioner of the department of state revenue or the commissioner's designee.**

**Sec. 3. (a) The term of an individual appointed as a member of the commission under section 2(1) of this chapter begins on the later of the following:**

**(1) The day the term of the member whom the individual is**

**appointed to succeed expires.**

**(2) The day the individual is appointed by the governor.**

**(b) The term of a member of the commission appointed under section 2(1) of this chapter expires July 1 of the fourth year after the member's current term begins.**

**(c) The governor may reappoint a member of the commission under section 2(1) of this chapter for more than one (1) term. A member reappointed by the governor is the member's own successor for purposes of subsection (a).**

**(d) The term of an individual appointed as a member of the commission under section 2(2) of this chapter begins January 1 after the organization of the first regular session of the general assembly from which the individual is appointed.**

**(e) The term of an advisory member of the commission appointed under section 2(2) of this chapter expires upon the election of the next general assembly.**

**(f) An appointing authority under section 2(2) of this chapter may reappoint a member serving under section 2(2) of this chapter for a new term.**

**(g) An individual serving as a member of the commission under section 2(3) of this chapter serves until the individual no longer holds the office under which the individual is a member of the commission.**

**Sec. 4. (a) The governor shall appoint an individual qualified under section 2(1) of this chapter to fill a vacancy of a member serving under section 2(1) of this chapter for the remainder of the unexpired term.**

**(b) The appropriate appointing authority under section 2(2) of this chapter shall fill a vacancy of a member of the commission serving under section 2(2) of this chapter for the remainder of the unexpired term.**

**Sec. 5. The commission shall elect a member of the commission serving under section 2(1) of this chapter to serve as presiding officer of the commission. The member elected under this section is the presiding officer of the commission until the earlier of the following:**

**(1) The member's term as a member of the commission expires.**

**(2) The member is replaced as presiding officer by the commission.**

**Sec. 6. (a) Each member of the commission who is not a state employee is entitled to the minimum salary per diem provided by**

**IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.**

**(b) Each member of the commission who is a state employee but who is not a member of the general assembly is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.**

**(c) Each member of the commission who is a member of the general assembly is entitled to receive the same per diem, mileage, and travel allowances paid to members of the general assembly serving on interim study committees established by the legislative council.**

**(d) The expenses paid under this section shall be paid from the fund.**

**Sec. 7. (a) Ten (10) voting members of the commission constitute a quorum.**

**(b) The commission may take action upon the affirmative vote of a majority of the voting members present. At least six (6) affirmative votes are necessary to take action. However, the election of a presiding officer requires the affirmative vote of at least ten (10) voting members.**

**Sec. 8. The commission shall meet at least one (1) time every month.**

**Sec. 9. At a commission meeting, the presiding officer shall provide an individual who wishes to be heard on a matter an adequate opportunity to present oral or written testimony.**

**Sec. 10. The commission shall administer this article.**

**Sec. 11. The commission may adopt rules under IC 4-22-2 to implement this article.**

**Sec. 12. (a) The commission shall employ an executive director who is the chief administrative officer of the commission.**

**(b) The executive director shall perform the duties required by this article and implement the policies of the commission.**

**Sec. 13. The executive director may hire staff for the commission.**

**Sec. 14. The executive director may delegate a power or duty of**

**the executive director under this article to a member of the staff of the commission.**

**Sec. 15. (a) The commission is the ultimate authority for purposes of a proceeding under this article and IC 4-21.5.**

**(b) Unless the executive director refers a matter to the committee for a recommendation, an agency action (as defined in IC 4-21.5-1-4) of the executive director may be appealed to the commission under IC 4-21.5.**

**(c) If the executive director refers a matter to the committee for a recommendation, a party may appeal a decision to the commission after the committee makes a recommendation to the executive director.**

**Sec. 16. The expenses of the commission shall be paid from the fund.**

**Sec. 17. (a) Each voting member of the commission must attend at least one (1) health care educational seminar each year.**

**(b) The reasonable costs of a member attending a seminar required by subsection (a) shall be paid from the fund.**

**(c) A nonvoting member of the commission is entitled to have the reasonable costs of attending one (1) health care educational seminar each year paid from the fund.**

**Sec. 18. The commission may contract with actuaries and other persons to implement this article. The expenses of the contract must be paid from the fund.**

**Chapter 4. Powers and Duties of the Commission**

**Sec. 1. The commission may enter into an agreement for payment to a provider that renders insured services to an insured on a basis other than a fee for service.**

**Sec. 2. (a) This section applies only to a provider who practices in an underserved area.**

**(b) The commission shall increase the negotiated fee schedule of a provider to one hundred fifteen percent (115%) of the schedule established for the provider's provider category.**

**(c) The increase required by subsection (b) is effective until the area is no longer an underserved area.**

**Sec. 3. The commission may enter into an agreement with a person for provision of insured services outside Indiana to an insured.**

**Sec. 4. The commission shall provide for enrollment of individuals in the plan.**

**Sec. 5. The commission shall determine eligibility for enrollment in the plan.**

**Sec. 6. The commission may determine whether particular health care services not listed in this article are insured services.**

**Sec. 7. The commission shall make recommendations to the general assembly regarding revenue necessary for operation of the plan.**

**Sec. 8. The commission may maintain legal actions and negotiate settlements.**

**Sec. 9. The commission may require and obtain information required under this article that is necessary to implement this article.**

**Sec. 10. The commission shall:**

**(1) enter into appropriate agreements with; or**

**(2) obtain necessary waivers from;**

**the federal government to extend coverage of the plan to as many residents of Indiana as possible.**

**Sec. 11. The commission may provide for an individual who is not otherwise entitled to become an insured under this article to become an insured upon payment of appropriate charges by or for the individual.**

**Sec. 12. (a) The commission may process claims:**

**(1) through the commission's own staff; or**

**(2) through a fiscal agent with which the commission contracts.**

**(b) The term of a contract entered into under subsection (a)(2) may be for a period of not more than three (3) years.**

**(c) A contract entered into under subsection (a)(2) must provide that notice of at least one (1) year must be given if either of the parties to the contract does not intend to renew the contract for an additional term.**

**Sec. 13. (a) This section applies only to insured individuals who have a:**

**(1) catastrophic;**

**(2) chronic; or**

**(3) terminal;**

**illness.**

**(b) Before January 1, 2011, the commission shall establish or contract for the managed care of individuals described in subsection (a).**

**(c) The commission shall require that only the most cost effective and highly qualified providers may be employed by the managed care system required by this section.**

**(d) The commission shall request as an option that an individual**

**described in subsection (a) participate in the managed care system established under this section.**

**(e) The commission shall establish a managed care capitation fee arrangement with the commission's managed care providers to furnish all medically necessary care.**

**Sec. 14. The commission shall provide public education on the quality and cost of health care so that consumers can make informed health care decisions.**

**Sec. 15. (a) The commission shall report to the general assembly in an electronic format under IC 5-14-6 regarding the following:**

**(1) The quality of health care in Indiana.**

**(2) The commission's efforts to contain health care costs.**

**(b) The commission shall submit the report required by this section in an electronic format under IC 5-14-6 to the legislative council before July 1 of each year. The report must cover the previous calendar year.**

**(c) A provider shall make available to the commission information the commission considers necessary to make the report required by this section.**

**Sec. 16. The commission shall promote development of uniform health claims cards readable by electronic card readers.**

**Sec. 17. (a) Before January 1, 2011, the commission shall present a proposal to the general assembly for inclusion of coverage of long term care in the plan.**

**(b) This section expires January 1, 2012.**

**Chapter 5. Health Insurance Plan**

**Sec. 1. The health insurance plan is established.**

**Sec. 2. The purpose of the plan is to provide insurance against the cost of health care services on uniform terms and conditions available to all residents of Indiana.**

**Sec. 3. An individual who is a resident of Indiana is entitled to become an insured upon application to the commission.**

**Sec. 4. If a dependent of an insured is not a resident, the dependent is entitled to become an insured upon application to the commission.**

**Sec. 5. (a) Subject to subsections (b) and (c), an insured is entitled to:**

**(1) reimbursement for payment the insured makes for insured services if the services are provided outside Indiana;**

**(2) payment on behalf of the insured for insured services; or**

**(3) the provision of insured services.**

**(b) Payment or provision of insured services is subject to**

**conditions required by the commission.**

**(c) Payment for insured services rendered outside Indiana may not exceed the amount that would have been paid for the same service if provided within Indiana.**

**Sec. 6. The commission may not restrict an insured's access to the health care system or insured services due to the type of provider the insured first consulted for health care services.**

**Sec. 7. Subject to this article, the commission shall adopt rules under IC 4-22-2 to establish the following:**

**(1) Plan benefits.**

**(2) Terms and conditions of coverage.**

**(3) Annual expenditure targets for fee for service providers.**

**(4) Allowable expenses that must be included in global and capital budgets for the following:**

**(A) Institutional providers of inpatient care services.**

**(B) Ambulatory care facilities for diagnosis, treatment, and care.**

**(5) Standards and procedures for negotiating and entering into contracts with participating providers.**

**(6) Other elements of the plan the commission considers necessary.**

**Sec. 8. (a) The plan must cover a service provided to an insured, regardless of the eligibility of the insured for Medicare, if the same service would be covered by Medicare if provided to an individual eligible for Medicare.**

**(b) In addition to the services covered under subsection (a), the plan must cover at least the following:**

**(1) Colorectal screening.**

**(2) Home care for an insured if:**

**(A) the insured is unable to perform at least two (2) activities of daily living; or**

**(B) the insured, due to cognitive or mental impairment, poses a health or safety risk to the insured or other individuals.**

**(3) Hospice care.**

**(4) Immunizations.**

**(5) Mammography (at least one (1) time a year).**

**(6) Postpartum care.**

**(7) Prenatal care.**

**(8) Reproductive health care.**

**(9) Substance abuse rehabilitation (limited to thirty (30) days a year as an inpatient and thirty (30) days a year as an**

**outpatient).**

**(10) Early periodic screening, diagnosis, and treatment.**

**(11) Treatment for musculo-skeletal disorders as covered under the state Medicaid program, as provided in the following:**

**(A) Medical services.**

**(B) Chiropractic services.**

**Sec. 9. (a) This section applies to an individual described by any of the following:**

**(1) The individual is at least sixty-five (65) years of age.**

**(2) The individual receives benefits under the federal Social Security Act.**

**(3) The individual's income is below the poverty level.**

**(b) In addition to the services listed in section 8 of this chapter, the plan must cover the following for an individual described in subsection (a):**

**(1) Dental services (excluding orthodontia).**

**(2) Prescription drugs.**

**(3) Vision/eye care.**

**Sec. 10. Subject to section 8(b) of this chapter, the plan may not cover the following:**

**(1) Cosmetic surgery other than reconstructive surgery.**

**(2) Reports for life insurance or legal purposes.**

**(3) Basic care in a nursing home.**

**Chapter 6. Health Insurance Trust Fund**

**Sec. 1. The health insurance trust fund is established.**

**Sec. 2. (a) The fund is a trust fund.**

**(b) A person does not have a right to any part of the fund except for payment for insured services as required by this article and by the rules of the commission.**

**Sec. 3. The fund shall be administered by the commission.**

**Sec. 4. The fund consists of the following:**

**(1) Revenue provided by statute and money appropriated by the general assembly.**

**(2) Federal funds covered by section 8 of this chapter.**

**(3) Other revenue received by the commission.**

**(4) Interest accruing from investment of money in the fund.**

**Sec. 5. (a) The treasurer of state shall hire a professional money manager to invest money in the fund not currently needed to meet the obligations of the fund in a manner similar to investment of other trust funds governed by ERISA.**

**(b) Interest that accrues from investments of the fund shall be**

**deposited in the fund.**

**Sec. 6. Money in the fund at the end of a state fiscal year does not revert to the state general fund.**

**Sec. 7. The fund may be used only for the following purposes:**

**(1) To pay the expenses of the commission.**

**(2) To make payments for insured services under this article.**

**(3) To make payments for operating and capital budgets of hospitals.**

**Sec. 8. (a) The budget agency shall identify all federal programs that provide federal money for payment of insured services.**

**(b) The governor shall direct the appropriate state agency to apply to the federal government for waivers of the requirements of any federal programs identified under subsection (a) to enable the state to deposit money provided by that program in the fund.**

**(c) Money from federal programs identified under subsection (a) for which a waiver has been obtained under subsection (b) shall be deposited in the fund.**

**Sec. 9. (a) Amounts necessary for uses permitted under section 7 of this chapter are appropriated to the commission.**

**(b) The money in the fund is not subject to allotment under IC 4-12 or transfer by the board of finance.**

**Sec. 10. (a) This section applies only after the plan has been operating for three (3) full months.**

**(b) The amount of reserves in the fund at any time must equal at least the amount of expenditures from the fund during the previous three (3) months.**

**(c) If after the period described in subsection (a) the reserves in the fund are less than the amount required by subsection (b), the commission shall report the fact to the following:**

**(1) The governor.**

**(2) The speaker of the house of representatives.**

**(3) The president pro tempore of the senate.**

**If the commission determines that reserves in the fund will not meet the requirement of subsection (b) before the next calendar quarter, the commission shall make recommendations to the governor and the general assembly for action to correct the situation. If the recommendations require action by the general assembly and the general assembly is not in session, the commission shall recommend that the governor call the general assembly into special session.**

**Sec. 11. (a) This section applies only after the plan has been operating for one (1) full calendar year.**

**(b) Expenditures from the fund during any calendar year may not be more than an amount determined in the last STEP of the following formula:**

**STEP ONE: Determine expenditures from the fund during the previous calendar year.**

**STEP TWO: Determine the population of Indiana during the previous calendar year.**

**STEP THREE: Project the population of Indiana for the current calendar year. The commission may use projections made by an agency of the federal government or obtained by any professionally recognized statistical means to determine the projected population of Indiana.**

**STEP FOUR: Divide the number determined in STEP THREE by the number determined in STEP TWO.**

**STEP FIVE: Multiply the number determined in STEP ONE by the number determined in STEP FOUR.**

**STEP SIX: Determine the nominal gross domestic product from the previous calendar year.**

**STEP SEVEN: Project the nominal gross domestic product for the current calendar year. The commission may use projections made by an agency of the federal government or obtained by any professionally recognized economic means to determine the projected nominal gross domestic product.**

**STEP EIGHT: Divide the number determined in STEP SEVEN by the number determined in STEP SIX.**

**STEP NINE: Multiply the number determined in STEP FIVE by the number determined in STEP EIGHT.**

**Sec. 12. The commission shall contract for an annual independent audit of the condition of the fund. The audit must include a review of the investment policies of the fund.**

**Sec. 13. The commission shall enter into appropriate agreements with the department of state revenue under IC 6-8.1-9-14 for collection of copayments under section 14 of this chapter and health fees imposed on individuals and employers under section 15 of this chapter. The department of state revenue shall prescribe the forms and procedures to be used to make payments described in this section. The department of state revenue shall deposit payments in the fund.**

**Sec. 14. (a) An insured receiving a service provided under the plan must pay a copayment determined under this section.**

**(b) Subject to the maximum yearly dollar limitations provided in subsection (c) and subject to the copayment amount specified in**

**subsection (d), the amount of a copayment for a service received by the insured equals the percentage of the cost of the service listed in the following schedule:**

| Insured's Adjusted Gross Income as a Percentage of the Federal Poverty Level | Copayment Percentage for the Year the Service Is Received |
|---|---|
| Not more than 100% | 0% |
| Over 100% but not over 200% | 3% |
| Over 200% but not over 300% | 4% |
| Over 300% but not over 400% | 5% |
| Over 400% but not over 500% | 7.5% |
| Over 500% but not over 600% | 10% |
| Over 600% but not over 700% | 12.5% |
| Over 700% but not over 800% | 15% |
| Over 800% | 20% |

**(c) The total amount of copayments for an individual in any year may not exceed the following:**

| Insured's Adjusted Gross Income as a Percentage of the Federal Poverty Level | Maximum Copayment for the Year the Service Is Received |
|---|---|
| Over 100% but not over 200% | $150 |
| Over 200% but not over 300% | $225 |
| Over 300% but not over 400% | $300 |
| Over 400% but not over 500% | $500 |
| Over 500% but not over 600% | $700 |
| Over 600% but not over 700% | $1,100 |
| Over 700% but not over 800% | $1,500 |
| Over 800% | $2,000 |

**(d) Subject to subsection (c), an insured shall pay a five dollar ($5) copayment for each provider visit.**

**(e) An individual shall annually pay the copayments required by this section to the department of state revenue not later than the date specified in IC 6-3-4-3.**

**Sec. 15. (a) The commission shall determine the costs of the plan**

**that are not reimbursed from taxes, grants, contributions, copayments, and other sources and provide for the assessment of health fees to:**

**(1) employers that employ individuals who reside in Indiana; and**

**(2) individuals who reside in Indiana and have adjusted gross income for the taxable year in which the health fee is imposed;**

**that are sufficient to cover the unreimbursed cost of the plan after the application of all credits permitted by this article. The commission may use projections made by an agency of the federal government or another qualified individual or entity to calculate fees.**

**(b) An individual shall annually pay the health fees required by this section to the department of state revenue not later than the date specified in IC 6-3-4-3 in the manner and in the form specified by the department of state revenue.**

**(c) An employer shall deposit estimated payments of the health fee at the times and in the manner provided for the payment of estimated adjusted gross income taxes by corporations under IC 6-3-4-4.1. The employer shall pay the total amount of the health fee imposed for a year not later than the date specified in in IC 6-3-4-3.**

**Sec. 16. (a) The health fees imposed under section 15 of this chapter on resident individuals shall be based on a sliding scale based on the adjusted gross income of the resident individuals. No health fee may be imposed on a individual who has adjusted gross income that is less than one hundred (100%) percent of the federal poverty level.**

**(b) The health fee schedule shall provide for a credit against the individual's health fee liability equal to the total copayments charged to the individual under section 14 of this chapter and each dependent of the individual, as determined under IC 6-3-1-3.5.**

**(c) If an individual and the individual's spouse file separate returns, the credit for the dependent shall be allowed on only one (1) of the returns in the manner specified by the department of state revenue.**

**Sec. 17. (a) The health fees imposed under section 15 of this chapter on employers shall be based on a sliding scale of health fees for employers that is based on the number of resident individuals employed by the employer in Indiana and the adjusted gross income of the taxpayer.**

**(b) The health fee schedule shall provide for a credit for**

**employers that incur health care costs under an enforceable insurance contract, collective bargaining agreement, or other health care program permitted under IC 16-48-10.**

**(c) The commission shall specify the maximum permissible credit that an employer may apply to the employer's liability for health fees.**

**Chapter 7. Payment for Insured Services**

**Sec. 1. (a) The commission shall develop payment methodologies for payment of providers that are consistent with the payment methodologies of the Medicare program, including the following:**

**(1) Diagnosis related group classifications.**

**(2) Resource based relative value scales for providers.**

**(b) The commission shall develop all of the following for the Indiana population less than sixty-five (65) years of age:**

**(1) New diagnosis related group classifications.**

**(2) New resource based relative value scales for providers.**

**(3) New weights for each of subdivisions (1) and (2) to reflect different consumption patterns among the Indiana population less than sixty-five (65) years of age.**

**(c) Subject to this chapter, a provider shall be paid according to the payment methodologies developed by the commission under this section.**

**Sec. 2. Subject to this chapter and the rules of the commission, a provider shall bill the commission for insured services provided to insureds.**

**Sec. 3. When a provider bills the commission under this chapter, the following apply:**

**(1) The commission shall make direct payment to the provider for insured services in accordance with the commission's coding standards.**

**(2) The provider may not bill an insured for any amount for the insured services.**

**(3) Payment by the commission for the insured services performed is payment in full for the insured services.**

**Sec. 4. (a) The commission may not make direct payment to a provider that does not bill the commission for payment under this chapter.**

**(b) Subject to limitations in this article on payments for insured services, an insured is entitled to reimbursement of payments for insured services from a provider who does not bill the commission.**

**Sec. 5. A provider must bill for insured services performed by the provider in the form prescribed by the commission.**

**Sec. 6. (a) A bill for insured services must be submitted to the commission not later than six (6) months from the date of performance of the insured services.**

**(b) The bill of a provider that performs an insured service for an insured must describe the particulars of the insured service as required by this article and the rules of the commission.**

**Sec. 7. (a) An insured is considered to have authorized a provider that performed insured services to provide the commission with the information regarding the insured services required by this article and the rules of the commission.**

**(b) Upon enrolling in the plan, an insured must sign a consent to release of information required under this article and the rules of the commission.**

**Sec. 8. Subject to section 10 of this chapter, the executive director shall:**

**(1) review and approve claims for insured services; and**

**(2) authorize payment for insured services;**

**in accordance with this article and the rules of the commission.**

**Sec. 9. (a) The executive director may recover an overpayment made to a provider for insured services.**

**(b) The executive director may deduct from the amount payable for insured services performed by a provider any overpayments previously made to the provider.**

**Sec. 10. If the executive director finds that, with respect to a bill for insured services, all or part of the services were not:**

**(1) performed;**

**(2) medically necessary;**

**(3) provided in accordance with accepted professional standards or practice; or**

**(4) as represented;**

**the executive director shall refer the matter to the committee for recommendation under IC 16-48-8.**

**Sec. 11. (a) If the executive director takes action under sections 8 through 10 of this chapter, other than to review and pay a bill as submitted, the executive director shall give notice of the action under this section to both of the following:**

**(1) The insured.**

**(2) The affected provider.**

**(b) In a notice under this section, the executive director shall provide the following information:**

**(1) The name of the insured.**

**(2) The name of the provider.**

**(3) A description of the services for which the claim was made.**

**(4) The dates services were claimed to have been provided.**

**(5) The amount payable under the plan for insured services.**

**(6) The action the executive director will take.**

**(7) The reasons for the action.**

**(8) How the insured or the provider may appeal the action of the executive director.**

**(9) Other information the executive director considers relevant.**

**Sec. 12. (a) Independent providers and noninstitutional providers shall be reimbursed on a fee for service schedule.**

**(b) Representatives of each provider specialty shall negotiate a fee for service rate of reimbursement annually with the commission.**

**Sec. 13. (a) Each hospital and institutional provider shall annually negotiate an operating budget with the commission.**

**(b) An operating budget may be used only for operating expenses.**

**Sec. 14. (a) Each hospital and institutional provider shall annually negotiate a capital budget with the commission.**

**(b) A capital budget may be used only for capital expenditures.**

**Chapter 8. Health Care Claims Review Committee**

**Sec. 1. (a) The commission shall appoint a health care claims review committee consisting of the following:**

**(1) Ten (10) members who represent providers. Not more than one (1) member appointed under this subdivision may be a member of the same licensed profession.**

**(2) Five (5) members who may not be providers or represent providers.**

**(b) A member or an employee of the commission may not be a member of the committee.**

**(c) A member of the committee serves on the committee until the member resigns or is replaced by the commission.**

**Sec. 2. The members of the committee shall be paid for services as determined by the commission.**

**Sec. 3. (a) Except as provided in sections 4 and 5 of this chapter, the committee shall sit in panels of three (3) members as follows:**

**(1) One (1) member of each panel must be a member appointed under section 1(a)(1) of this chapter.**

**(2) One (1) member of each panel must be a member appointed under section 1(a)(2) of this chapter.**

**(b) The commission may designate the individuals who sit on a particular panel of the committee.**

**(c) Unless the whole committee hears a matter under section 4 of this chapter, the recommendation of a panel is considered a recommendation of the committee.**

**Sec. 4. The commission or the executive director may require the entire committee to make a recommendation on a matter.**

**Sec. 5. If a matter referred to the committee concerns a provider category that is not represented on the committee, the executive director shall form a special panel to hear the matter consisting of the following members:**

**(1) One (1) member appointed under section 1(a)(1) of this chapter.**

**(2) One (1) member appointed under section 1(a)(2) of this chapter.**

**(3) One (1) individual selected at random from a list of representatives:**

**(A) of the provider category not represented on the committee; and**

**(B) approved by the commission.**

**Sec. 6. The committee shall make a recommendation to the executive director regarding a matter referred to the committee under IC 16-48-7.**

**Sec. 7. (a) Except as provided under section 10 of this chapter, proceedings of the committee are not subject to IC 4-21.5.**

**(b) The commission shall adopt rules under IC 4-22-2 to specify procedures for the committee. The rules must include procedures for designating a panel to hear a matter.**

**(c) The commission shall adopt rules under IC 4-22-2 to implement this article.**

**Sec. 8. The committee may refer a matter to a board for advice on a recommendation.**

**Sec. 9. The committee may recommend that the executive director take any of the following actions:**

**(1) Pay a claim.**

**(2) Not pay a claim.**

**(3) Reduce the payment of the amount of a claim.**

**(4) Require reimbursement of an overpayment made on a claim.**

**Sec. 10. (a) The executive director shall give notice to a party of a recommendation of the committee.**

**(b) A recommendation of the committee is subject to review by**

**the commission under IC 4-21.5.**

**Sec. 11. Subject to section 10 of this chapter, the executive director shall implement a recommendation of the committee.**

**Sec. 12. The commission shall provide support and administrative services to the committee.**

**Chapter 9. Investigations**

**Sec. 1. The executive director shall establish an audit division to implement this chapter.**

**Sec. 2. The audit division has the following duties:**

**(1) To examine books, accounts, and reports of providers.**

**(2) To review medical records maintained by providers with respect to services provided to an insured.**

**(3) As directed by the commission, to audit loans made under the loan program established under IC 16-48-14.**

**Sec. 3. (a) The executive director shall establish as a program of the commission, and the audit division shall implement, the current applicable provisions of the Medicare fraud and abuse program.**

**(b) The attorney general shall assist the audit division in enforcement of the fraud and abuse program established under subsection (a).**

**Sec. 4. A person shall make all books, accounts, records, and other data required for an audit available to the commission at a convenient location within thirty (30) days after a written request made by the executive director.**

**Sec. 5. A person may not obstruct an employee of the division who is performing duties under this article.**

**Sec. 6. The executive director may apply for a search warrant under IC 35-33-5 to implement this article.**

**Sec. 7. To the extent practical, audits must be coordinated with other audits performed by the state.**

**Sec. 8. An audit performed under this chapter is at the expense of the commission.**

**Chapter 10. Private Health Insurance Contracts**

**Sec. 1. This chapter does not apply to any of the following:**

**(1) A contract entered into by the commission to provide insured services to insureds.**

**(2) A contract for administrative services entered into by the commission.**

**(3) A contract for reinsurance entered into by the commission.**

**(4) A contract relating to providing health care outside Indiana.**

**(5) A contract relating to providing health care that is not an**

**insured service.**

**(6) A contract to provide compensation for the loss of time from usual or normal activities because of disabilities requiring insured services.**

**(7) A contract that is an insurance contract for the benefit of an Indiana resident:**

**(A) whose principal employment is:**

**(i) outside Indiana; or**

**(ii) with the federal government or an agency or instrumentality of the federal government; and**

**(B) who is covered by the contract because of employment.**

**(8) A contract relating to providing health care for an individual who is not a resident.**

**Sec. 2. (a) This section does not apply to a health insurance contract entered into before January 1, 2011.**

**(b) A health insurance contract is unenforceable in Indiana.**

**Sec. 3. (a) A health insurance contract in force before January 1, 2008, may not be renewed after December 31, 2010.**

**(b) An insurance contract renewed after December 31, 2010, is unenforceable.**

**Sec. 4. After December 31, 2010, a person may not enter into or renew an insurance contract.**

**Sec. 5. A resident may not accept or receive a benefit under an insurance contract that is unenforceable under section 2 or 3 of this chapter.**

**Sec. 6. This article does not prohibit a collective bargaining agreement from providing for health care services or benefits to employees of an employer in addition to health care services or benefits that are insured services.**

**Sec. 7. A collective bargaining agreement may provide that an employer reimburse or compensate employees for costs incurred by employees for health care services that are insured services, including the following costs:**

**(1) Copayments and other charges that are required to be paid by an insured under this article.**

**(2) Any taxes for which employees are liable under IC 16-48-6-15.**

**Sec. 8. An employer that provides health care services or benefits to employees of an employer in addition to health care services or benefits that are insured services may not reduce the services or benefits.**

**Chapter 11. Subrogation**

**Sec. 1. (a) If an insured suffers personal injuries or death:**

**(1) caused by the wrongful act or omission of another person; and**

**(2) for which the insured receives insured services under the plan;**

**the commission shall contract out to recover the cost incurred for past insured services and the cost that will be incurred for future insured services. However, the commission is entitled to negotiate and establish a fee schedule for payment of legal service costs incurred in any recovery action.**

**(b) The commission claiming subrogation or reimbursement rights under this section shall pay out of the amount received from the insured the commission's pro rata share of the costs and expenses of asserting the third party claim. The commission shall negotiate the expenses of a third party claim based on the costs and expenses of asserting the third party claim. The costs and expenses include the following:**

**(1) Deposition costs.**

**(2) Witness fees.**

**(3) Attorney's fees.**

**(c) If the commission claims subrogation or reimbursement as a result of the payment of medical expenses or other benefits related to a claim for personal injuries or death and the insured's recovery is diminished by:**

**(1) comparative fault; or**

**(2) the uncollectibility of the full value of the claim for personal injuries or death that results from limited liability insurance or another cause;**

**the claim for subrogation and reimbursement must be diminished in the same proportion as the claimant's recovery is diminished. The commission shall pay a pro rata share of the claimant's attorney's fees and litigation expenses.**

**Sec. 2. (a) This section does not apply if the executive director grants a waiver.**

**(b) A person who commences an action to recover for loss or damages for injuries:**

**(1) arising out of the negligence or wrongful act of a third person; and**

**(2) for which insured services have been paid by the commission;**

**must include a claim on behalf of the commission for the cost of insured services.**

**Sec. 3. (a) This section applies to an action, including a claim for the cost of insured services required under section 2 of this chapter.**

**(b) The court shall, if the evidence permits, apportion the elements of the insured's loss and damages to designate both of the following:**

**(1) The amount of the commission's recovery for the past costs of insured services.**

**(2) The amount of the commission's recovery of future costs of insured services, if any.**

**Sec. 4. Unless the commission has approved the release or settlement, a release or settlement of a claim for damages for personal injuries in a case in which an insured has received insured services is not binding on the commission.**

**Sec. 5. (a) A liability insurer must notify the commission of negotiations for settlement of a claim for damages, including insured services for an insured.**

**(b) A liability insurer may pay to the commission any amount of the cost of insured services relating to a claim for recovery of the cost of the insured services for an insured. Payment by a liability insurer under this subsection discharges the obligation of the liability insurer to pay that amount to the person insured under the policy of liability insurance.**

**Sec. 6. If a judgment or settlement includes the future cost of insured services, the plan shall provide for the future insured services included in the judgment or settlement.**

**Sec. 7. If a person recovers a sum in respect of the cost of insured services paid by the commission, the person shall pay the sum to the commission as soon as possible.**

**Sec. 8. The commission is subrogated to the right of a provider or an insured to recover the cost of insured services provided to an insured who has an insurance contract not prohibited by IC 16-48-10.**

**Sec. 9. The commission may bring an action in the commission's own name to recover costs for which the commission has the right of subrogation under this chapter.**

**Chapter 12. Employer Health Payments by Governmental Bodies**

**Sec. 1. Subject to section 6 of this chapter, this chapter does not apply to the following governmental bodies:**

**(1) The federal government or an agency or instrumentality of the federal government.**

**(2) The government of a state of the United States other than the government of Indiana.**

**(3) A political subdivision of a state other than a political subdivision of Indiana.**

**Sec. 2. As used in this chapter, "employee" has the meaning set forth in IC 6-3-1-6.**

**Sec. 3. A governmental body shall pay to the department of state revenue the amount equal to the amount required by IC 16-48-6-15 to be paid by employers subject to IC 16-48-6-15 for each individual employed for each month or part of a month as an employee by the governmental body.**

**Sec. 4. A governmental body shall report and pay the amount required by section 3 of this chapter before the fifteenth day of the month following the month for which the payment is required.**

**Sec. 5. (a) There is annually appropriated from each appropriate fund of the state an amount necessary to pay the amounts required to be paid by the state under this chapter.**

**(b) Each political subdivision shall appropriate the amount required to be paid under section 3 of this chapter from the appropriate funds of the political subdivision.**

**Sec. 6. (a) A governmental body of the type listed in section 1 of this chapter may make a contribution to the fund for the benefit of employees of the governmental body who are insureds.**

**(b) A contribution made under this section shall be made to the department of state revenue.**

**(c) The department of state revenue may not accept a contribution from a governmental body under this section unless the governmental body agrees to do all the following:**

**(1) Pay an amount equal to the amount required by IC 16-48-6-15 to be paid by employers subject to IC 16-48-6-15 for each insured employed for each month or part of a month by the governmental body during the calendar year.**

**(2) Pay the amounts required to be paid to the department of state revenue before the fifteenth day of the month following the month for which payment is required.**

**(3) Withhold, report (including reports to insured employees required by IC 16-48-15), and pay the individual health insurance contribution assessment for insureds employed by the governmental body at any time during the calendar year as provided in IC 16-48-15.**

**Sec. 7. The department of state revenue shall deposit revenue**

**derived from payments and contributions made under this chapter into the fund.**

**Chapter 13. Clinical Panels**

**Sec. 1. The commission shall develop information concerning the best available knowledge about the provision of health care under given circumstances and distribute the knowledge to providers throughout Indiana.**

**Sec. 2. The commission may establish panels of practitioners from a variety of health care practices to develop the information described in section 1 of this chapter.**

**Sec. 3. The commission shall establish panels to consider high cost, high risk, and high volume procedures.**

**Sec. 4. (a) The governor shall appoint the members of a panel established by the commission.**

**(b) A member of a panel must have the following qualifications:**

**(1) Superior clinical, health care, or scientific expertise.**

**(2) Recognition by the individual's peers as an outstanding practitioner or scientist.**

**(c) A panel must include all the following:**

**(1) Generalist physician providers.**

**(2) Specialty providers.**

**(3) Providers other than those specified in subdivisions (1) and (2).**

**(d) When establishing a panel, the commission must provide for both of the following:**

**(1) Initial terms of members that expire on a staggered basis.**

**(2) Four (4) year terms for members after expiration of initial terms.**

**Sec. 5. A panel established under this chapter may do the following:**

**(1) Review existing and new practice guidelines developed by nationally recognized organizations.**

**(2) Develop new practice guidelines at the direction of the commission.**

**(3) Make recommendations to the commission for adoption of the best practice guidelines.**

**Sec. 6. In making recommendations of guidelines to the commission, a panel shall rely on the following in the following order of priority:**

**(1) Medical outcomes studies when available.**

**(2) Clinical practice guidelines (patterns of practice and collective judgment of health care providers).**

**(3) Normative data.**

**Sec. 7. (a) Each member of a panel who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.**

**(b) Each member of a panel who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.**

**Sec. 8. The costs of the work of a panel shall be paid from the fund as determined by the commission.**

**Chapter 14. Primary Care Provider Education Loan Program**

**Sec. 1. This chapter applies only to primary care providers practicing in the following areas:**

**(1) Family practice.**

**(2) General practice.**

**(3) Internal medicine.**

**(4) Obstetrics and gynecology.**

**(5) Pediatrics.**

**(6) Nursing, including as a nurse practitioner or nurse midwife.**

**(7) Physician assistants regulated by IC 25-27.5.**

**(8) Social work.**

**(9) Osteopathic medicine.**

**(10) A health care practice considered necessary by the commission.**

**Sec. 2. The commission may establish a loan program for students who meet the following criteria:**

**(1) The student plans to become a primary care provider.**

**(2) The student agrees to practice as a primary care provider in an underserved area (for that primary care provider category) in Indiana for seven (7) years.**

**(3) The student attends a school that, to the satisfaction of the commission, has established programs to increase the number of primary care provider graduates from the school.**

**(4) Any other qualification established by the commission**

**related to the goal of increasing the number of primary care providers in underserved areas of Indiana.**

**Sec. 3. A program established under this chapter may not provide a loan to a student for more than the total actual cost of tuition incurred by the student for the student's education as a primary care provider.**

**Sec. 4. The commission shall provide for the interest rates to be paid on loans made under the program. The commission shall fix interest rates for the loans to advance the purposes of the program.**

**Sec. 5. The commission shall provide that a loan and the interest on a loan may be forgiven as provided by the commission if the student meets the requirements of the program.**

**Sec. 6. A student or primary care provider who materially violates the requirements of this chapter or of the program is liable for the following, as determined by the commission:**

**(1) The full amount of the loan.**

**(2) All interest.**

**(3) All expenses incurred, including attorney's fees, in collection of the amounts described in subdivisions (1) and (2).**

**Chapter 15. Prohibition Against Self Referrals**

**Sec. 1. As used in this chapter, "facility" means any of the following:**

**(1) A clinical laboratory.**

**(2) A comprehensive rehabilitation center.**

**(3) A diagnostic imaging center.**

**(4) A radiation therapy center.**

**Sec. 2. Except as provided in section 3 of this chapter, a provider may not receive any consideration for referring a patient to a facility in which the provider has a financial interest.**

**Sec. 3. A provider may receive consideration for referring a patient to a facility in which the provider has a financial interest only if all of the following apply:**

**(1) The facility is owned by, or under the control of, a corporation.**

**(2) Stock in the corporation is traded over the counter or on a national exchange.**

**(3) The assets of the corporation are more than fifty million dollars ($50,000,000).**

**(4) The provider holds less than fifty percent (50%) of the value of the stock of the corporation.**

**(5) Any conditions for purchase of the stock of the corporation do not require referral of patients.**

**(6) Income from investment in the corporation is not related to volume of referrals.**

**Sec. 4. (a) The commission may impose a civil penalty on a provider that the commission finds has violated section 2 of this chapter.**

**(b) IC 4-21.5 applies to a proceeding under this section.**

**(c) A civil penalty imposed under this section may not exceed fifteen thousand dollars ($15,000) for each violation.**

**(d) A civil penalty imposed under this section shall be paid into the fund.**

SECTION 36. [EFFECTIVE JULY 1, 2007] **(a) As used in this SECTION, "commission" refers to the health insurance commission established by IC 16-48-3-1, as added by this act.**

**(b) The governor shall appoint the members of the commission under IC 16-48-3-2(1), as added by this act, before January 1, 2008.**

**(c) Notwithstanding IC 16-48-3-3, as added by this act, the initial terms of the members of the commission expire as follows:**

**(1) The term of one (1) member appointed under each of the following statutes expires July 1, 2009:**

**(A) IC 16-48-3-2(1)(A), as added by this act.**

**(B) IC 16-48-3-2(1)(B), as added by this act.**

**(C) IC 16-48-3-2(1)(C), as added by this act.**

**(D) IC 16-48-3-2(1)(D), as added by this act.**

**(2) The term of one (1) member appointed under each of the following statutes expires July 1, 2010:**

**(A) IC 16-48-3-2(1)(A), as added by this act.**

**(B) IC 16-48-3-2(1)(B), as added by this act.**

**(C) IC 16-48-3-2(1)(E), as added by this act.**

**(3) The terms of two (2) members appointed under IC 16-48-3-2(1)(C), as added by this act, expire July 1, 2010.**

**(4) The term of one (1) member appointed under each of the following statutes expires July 1, 2011:**

**(A) IC 16-48-3-2(1)(A), as added by this act.**

**(B) IC 16-48-3-2(1)(B), as added by this act.**

**(C) IC 16-48-3-2(1)(D), as added by this act.**

**(5) The terms of two (2) members appointed under IC 16-48-3-2(1)(C), as added by this act, expire July 1, 2011.**

**(6) The term of one (1) member appointed under each of the following statutes expires July 1, 2012:**

**(A) IC 16-48-3-2(1)(A), as added by this act.**

**(B) IC 16-48-3-2(1)(B), as added by this act.**

**(C) IC 16-48-3-2(1)(E), as added by this act.**

**(7) The terms of two (2) members appointed under IC 16-48-3-2(1)(C), as added by this act, expire July 1, 2011.**

**(d) Subject to this SECTION, when appointing a member of the commission under this SECTION, the governor shall specify when the term of a member expires.**

**(e) This SECTION expires July 1, 2013.**

SECTION 37. [EFFECTIVE JULY 1, 2007] **(a) As used in this SECTION, "commission" refers to the health insurance commission established by IC 16-48-3-1, as added by this act.**

**(b) The speaker of the house of representatives and the president pro tempore of the senate shall appoint the advisory members of the commission under IC 16-48-3-2(2), as added by this act, before January 1, 2008.**

**(c) This SECTION expires January 1, 2009.**

SECTION 38. [EFFECTIVE JULY 1, 2007] **(a) As used in this SECTION, "commission" refers to the health insurance commission established by IC 16-48-3-1, as added by this act.**

**(b) As used in this SECTION, "ERISA" refers to the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.).**

**(c) As used in this SECTION, "insured services" has the meaning set forth in IC 16-48-1-17, as added by this act.**

**(d) As used in this SECTION, "Medicaid program" refers to the program established under IC 12-15 and 42 U.S.C. 1396 et seq.**

**(e) As used in this SECTION, "Medicare program" refers to Parts A, B, and D of the Medicare program (42 U.S.C. 1395 et seq.).**

**(f) As used in this SECTION, "plan" refers to the Indiana health insurance plan established by IC 16-48-5-1, as added by this act.**

**(g) As used in this SECTION, "veterans benefits" refers to health care benefits that a veteran (as defined in 38 U.S.C. 101) is entitled to under 38 U.S.C. 1701 et seq.**

**(h) Notwithstanding IC 16-48, as added by this act, the commission is not required to provide for coverage of insured services before the later of the following:**

**(1) January 1 of the year after the state has obtained appropriate approvals, assurances, or waivers from the federal government for all the following:**

**(A) That the plan may be implemented, notwithstanding ERISA.**

**(B) That money paid to the state under the Medicaid program may be paid to the commission for**

**reimbursement of insured services:**

**(i) paid by the plan; and**

**(ii) covered by the Medicaid program.**

**(C) That money paid to providers under the Medicare program will be paid to the commission for reimbursement of insured services:**

**(i) paid by the plan; and**

**(ii) covered by the Medicare program.**

**(D) That money paid to providers as veterans benefits will be paid to the commission for reimbursement of insured services.**

**(2) The budget agency determines that there are sufficient federal, state, and local funds to operate the plan as required by IC 16-48, as added by this act, including the reserve requirements of IC 16-48-6-10, as added by this act. Before July 1, 2009, the commission and the budget agency shall report to the governor and the budget committee concerning funding of the plan. The budget committee may hold hearings and exercise other powers of the budget committee under IC 4-12 regarding the funding of the plan.**

**(i) If all the approvals, assurances, or waivers described in subsection (h)(1) have not been obtained before October 1, 2009, the commission shall make appropriate recommendations to the 2010 regular session of the general assembly for legislation to modify or, if necessary, to repeal the plan.**

**(j) If the report of the commission and the budget agency made under subsection (h)(2) concludes that there are not sufficient funds to operate the plan as required by IC 16-48, as added by this act, the commission and the budget agency shall recommend introduction of legislation in the 2010 regular session of the general assembly to repeal the plan.**

**(k) This SECTION expires July 1, 2012.**

SECTION 39. [EFFECTIVE JULY 1, 2007] **(a) As used in this SECTION, "governmental body" has the meaning set forth in IC 16-48-1-13, as added by this act.**

**(b) Notwithstanding IC 16-48-12-3, as added by this act, a governmental body required to make a payment to the department of state revenue under IC 16-48-12-3, as added by this act, is not required to make a payment before January 1, 2009.**

**(c) This SECTION expires January 1, 2010.**

SECTION 40. [EFFECTIVE JULY 1, 2007] **(a) Notwithstanding IC 16-48-3-12, as added by this act, the commissioner of the state**

**department of health shall serve as a temporary executive director until the health insurance commission has employed a full-time executive director.**

**(b) Notwithstanding IC 16-48-3-13, as added by this act, the state department of health shall provide staff for the health insurance commission until a full-time executive director has been employed.**

**(c) This SECTION expires July 1, 2009.**

SECTION 41. [EFFECTIVE JULY 1, 2007] **(a) As used in this SECTION, "commission" refers to the health insurance commission established by IC 16-48-3-1, as added by this act.**

**(b) There is appropriated to the commission forty-nine thousand dollars ($49,000) from the state general fund to carry out the commission's duties under this act beginning January 1, 2008, and ending December 31, 2010.**

**(c) This SECTION expires January 1, 2012.**

SECTION 42. [EFFECTIVE JULY 1, 2007] **Notwithstanding IC 6-7-1-14, revenue stamps paid for before July 1, 2007, and in the possession of a distributor may be used after June 30, 2007, only if the full amount of the tax imposed by IC 6-7-1-12, as effective after June 30, 2007, and as amended by this act, is remitted to the department of state revenue under procedures prescribed by the department.**